Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBC INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TEXAS 75243

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-12-1929-01

MFDR Date Received

February 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were denied per EOB based on the findings of a review organization. CPT codes 97545 WHCA & 97546 WHCA were preauthorized, #41260 therefore it is deemed medically necessary. Per DWC Rule 133.301 (a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or services(s) for which the medial care provider has obtained preauthorization under Rule 134.600(h)."

Amount in Dispute: $2,048.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the EOB (attached) reflect the services were billed and paid as part of other services. The reimbursement was denied under Texas Labor Code 413.042 as the billing was an attempt at balanced billing, impermissible under the Texas Labor Code. The benefits or services provided were already included in a payment allotted under an [sic] other procedure provided to the claimant and thus disallowed in a separate or balanced billing...With regard to the claim of 'impermissible retrospective review' the Requestor is incorrect. The denial of the services were not based on a retrospective review but instead as outlined above, the inclusion of the services as part of other treatment or services. Accordingly, the Division should not review and evaluate the Respondent's denial as part of a retrospective review."

Response Submitted by: Lewis & Backhaus, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2011 through October 11, 2011	CARF accredited work hardening	$2,048.00	$2,048.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 adopted to be effective December 31, 2006, 31 TexReg 10314, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.600 sets out the preauthorization requirements.
3. 28 Texas Administrative Code §134.204 adopted to be effective March 1, 2008, 33 TexReg 364, sets out the reimbursement for workers' compensation specific codes, services and programs provided in the Texas workers' compensation system.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 26, 2011, December 8, 2011 and January 17, 2012
   - 216 – Based on the findings of a review organization

   Explanation of benefits dated December 8, 2011
   - 97 – The benefit for this services is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 216 – Based on the findings of a review organization
   - 1 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed

Issues

1. Did the requestor obtain preauthorization for the disputed CARF accredited work hardening program?
2. Did the requestor document the disputed services?
3. Did the carrier identify what codes were billed on the same day as the work hardening program that would cause NCCI edits?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600, the requestor submitted a copy of a preauthorization letter (#41260) to support that preauthorization was obtained for the disputed dates of service, September 26, 2011 through October 11, 2011. Therefore, the disputed charges are not subject to retrospective review and will be reviewed according to the applicable fee guidelines.
2. Review of the preauthorization letter dated September 19, 2011 revealed that IMO, preauthorized work hardening treatment to be rendered September 19, 2011 through October 19, 2011 under preauthorization #41260. Review of the documentation submitted by the requestor supports that the CARF accredited work hardening program was provided on September 26, 2011 through October 11, 2011, within the preauthorization timeframe.
3. Review of the work hardening notes, document the injured employee started the work hardening program at 8:00 am with a completion time of 4:00 pm, the requestor billed for 7 hours, therefore the requestor documented the hours billed. Reimbursement is therefore recommended for the disputed charges.
4. Per 28 Texas Administrative Code §134.204, “(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.
   - The requestor billed CPT code 97545-WH-CA and 97546-WH-CA
5. Per 28 Texas Administrative Code §134.204(h)(1)(A) “If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.
   - The requestor appended modifier -CA to both 97545 and 97546
6. Per 28 Texas Administrative Code §134.204(h)(3)(A-B) (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

- The requestor billed and documented 8 hours of a work hardening program

7. Review of the CMS-1500's submitted by the requestor documents that the health care provider billed for 97545-WH-CA and 97546-WH-CA along with CPT code 99082, for each disputed dates of service. The billed services are not bundled and NCCI edits conflicts exists. Therefore, the insurance carrier has not supported the denial reason of bundled to reduce/deny the disputed charge.
8. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $2,048.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,048.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,048.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 22, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.